Department of Labor Audits

Persistent action on legislative compliance is critical to your organization. Proactive compliance goes beyond filing specific paperwork by specific deadlines. It means understanding how laws and regulations apply to your employee benefits offerings and how to minimize the costs associated with noncompliance to maximize your organization's resources to ensure continuous operations, attracting and engaging employees, and overall organizational wellbeing.

Compliance Continuity is designed to help your organization sustain the total wellbeing and engagement of your workforce, pursue your business goals, and help you achieve better results by providing ongoing benefits and HR compliance guidance, key considerations, and action steps. While your best is finite, your better is never finished. Check out the action steps below to help you proactively plan a path toward preparing for a U.S. Department of Labor ("DOL") Audit.

1. Summarize. Supplement. Wrap. As a plan administrator, you (the employer), not your insurance carrier (or your third-party administrator), are responsible for providing summary plan descriptions ("SPDs"). There are more than 26 items that must be included in an SPD for it to be ERISA-compliant. Frequently, insurance carriers will provide certificate booklets that contain some of the necessary information, but not all. Documents from third-party administrators are sometimes incomplete. For that reason, plan administrators usually have to provide additional information in the form of an "SPD supplement" or "mini-wrap" document, which, along with the certificate booklet or other plan materials, fills in the missing information. ***What supplemental information is necessary to maintain an ERISA-compliant SPD?***

2. Mail? Email? Post? SPDs must be furnished to all participants covered by the plan. These participants include often overlooked participants, such as those covered by the Consolidated Omnibus Reconciliation Act ("COBRA"), qualified beneficiaries, retirees, and alternate recipients on the plan by virtue of Qualified Medical Child Support Orders ("QMCSOs") or National Medical Support Notices. Employers often overlook COBRA qualified beneficiaries and children covered under QMCSOs. Furthermore, DOL regulations specifically approve of distributing SPDs by first class mail, but SPDs may only be distributed electronically if certain requirements are met. Posting the SPD on an organization's intranet is typically not sufficient, and there are specific rules about how materials may be distributed to employees without work-related computer access. Plans must follow specific rules for electronic disclosures, and additional disclosures may be required. ***What process does your organization have in place to ensure you are distributing SPDs according to DOL rules?***

3. Inform. Allow. Enroll. Group health plans are required to allow employees, their spouses, and dependents to enroll in their plans at specified times without being treated as late entrants. These other entry dates, called special enrollments, are as follows: (a) upon the involuntary loss of eligibility for other group coverage; (b) upon the marriage of the employee; (c) upon the birth or adoption of a child; and (d) upon the loss of Medicaid or State Children's Health Insurance Program ("SCHIP") coverage or gaining eligibility for state premium assistance. The Health Insurance Portability and Accountability Act ("HIPAA") requires plans to provide all employees (those who enroll and those who decline enrollment) with a notice of special enrollment at, or before the time the employee is offered the opportunity to enroll. You can include the notice of special enrollment rights on plan enrollment forms or on a separate form that is included with enrollment materials, but you should likely avoid providing the notice solely in your SPD because individuals who decline coverage will not receive SPDs. ***How does your plan ensure that it provides notice of the required HIPAA special enrollment rights?***

4. Incentivize. Disclose. Waive? HIPAA sets forth certain requirements for wellness programs where a reward is offered under a health plan based on a health factor (e.g., smoker/non-smoker premium differentials; deductible credit for achieving a certain BMI or cholesterol score; etc.). Additionally, HIPAA requires wellness program rewards be available to all similarly situated individuals. If it is unreasonably difficult for an individual to qualify for the reward due to a medical

condition, or if it is medically inadvisable for an individual to satisfy the applicable health standard, the program must allow a reasonable alternative standard or a waiver of the underlying standard. Furthermore, the program must disclose (in all materials describing the terms of the program, including annual enrollment materials) the availability of a reasonable alternative standard – or the possibility of a waiver of the underlying standard, if applicable. The DOL has been inquiring about wellness program communication materials, and specifically the inclusion of the required disclosure statement. ***Which of your wellness program materials include the required disclosure statement regarding the availability of a reasonable alternative?***

5. Cover. Describe. Include. The Newborns' and Mothers' Health Protection Act ("NMHPA") prohibits group health plans from restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a vaginal delivery, to less than 48 hours, or following a cesarean section, to less than 96 hours. Often the DOL requests a plan's NMHPA notice, as well as a list or logs an administrator may keep of issued notices. In addition, NMHPA provisions describing a mother's and newborn's rights must be included in your plan's SPD. A separate notice is only required where a self-funded non-federal governmental plan, such as the self-funded plan of a city, county, public school district or municipality, has opted out of the NMHPA. In such a case, the plan must provide notice to enrollees, annually and upon enrollment indicating the plan opted out. Employers should be careful to stay up to speed on the intricacies of NMHPA disclosure requirements. ***How does your plan ensure that it meets the NMHPA disclosure requirements?***

6. Document. Maintain. Process. The Women's Health and Cancer Rights Act ("WHCRA") requires group health plans that provide medical and surgical benefits for mastectomies and to provide benefits for reconstructive surgery after a mastectomy. In addition to coverage requirements, plans must also meet notice requirements. The WHCRA notice must be provided upon enrollment as well as annually. Employers should be careful to develop a strategy to meet both distribution requirements and demonstrate compliance. As a best practice, plan sponsors should maintain the following documentation: plan documents and amendments, SPDs, initial and annual notices, enrollment dates, and documentation of the process to distribute notices. ***What improvements to your WHCRA notice distribution process should you make?***

7. Demonstrate. Document. Comply. The Mental Health Parity and Addiction Equity Act ("MHPAEA") requires that a plan with annual dollar limits or aggregate lifetime dollar limits for medical/surgical benefits apply those same or more generous dollar limits to mental health benefits, and a plan's financial requirements for mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applying to substantially all medical/surgical benefits under the plan. DOL inquiries have included a significant focus on these requirements. Employers should not simply rely upon their carriers or third-party administrators when it comes to compliance with mental health parity. Plan administrators should be prepared to show criteria for medical necessity determinations for mental health and substance use disorder benefits; legal and actuarial opinions it relied on for parity compliance, including any actuarial cost-increase calculations used to claim an increased cost exemption; and the methodology your plan used to determine parity compliance. ***What additional steps should your plan take to document full compliance with the mental health parity requirements?***

8. Cover. Comply. Establish. If your plan does not claim grandfathered status under the Patient Protection and Affordable Care Act ("PPACA"), your plan must be compliant with required additional mandates. The mandates applicable to non-grandfathered plans include: (a) patient protections such as the right to designate any primary care provider (and related rules with respect to designating a pediatrician in the case of a child or OB/GYN for a woman); (b) coverage of out-of-network emergency services on the same basis as in-network emergency services; (c) first-dollar coverage of preventive services; and (d) compliance with internal claim and appeals procedures and the new external review process. The DOL has requested documentation demonstrating plans' compliance with these rules, in addition to related notice and disclosure rules. Regardless of your plan's grandfathered or non-grandfathered plan status, several important

mandates became effective for plan years beginning on or after September 23, 2010. The information requests can include inquiries about: (a) extending dependent eligibility under the plan to age 26 and the related special enrollment and notice requirement; (b) the details of any rescissions of coverage under the plan the related required notice; (c) any lifetime limits imposed under the plan; and (d) any annual limits imposed under the plan. ***How well does your plan documentation establish compliance with PPACA mandates related to coverage requirements?***

9. Notify. Notify. Notify. Under COBRA, group health plans subject to ERISA that are sponsored by employers with 20 or more employees must offer health care continuation coverage to certain individuals called qualified beneficiaries who lose health coverage based on certain events called qualifying events. The requirements apply regardless of the funding method and apply to all types of health coverage, not just medical. Both the IRS and the DOL have regulatory authority to enforce provisions of COBRA; while coverage, election, and enrollment requirements will generally fall under IRS regulation, the DOL enforces the notice provisions. Thus, organizations subject to DOL audit likely also will be audited for compliance with COBRA notice obligations. COBRA requires group health plan administrators and qualified beneficiaries to provide certain notices to each other within specified time frames. Plan administrators must provide the following notices: a general notice; notice of certain qualifying events (employer to plan administrator); election notice; premium rate change notification; conversion rights (if applicable); notice of unavailability of continuation coverage; notice of early termination (before 18, 29 or 36 months maximum as applicable); insufficient premium notification; and notice of status of COBRA coverage to health care providers (if applicable). ***Are any improvements necessary for your COBRA notice documentation process?***

10. Seek. Consult. Strategize. If your organization is selected for a DOL audit, consider retaining ERISA counsel to assist you in responding to the audit. While your consultants and vendors should be able to help you compile many of the documents and records you will need, it is best to respond to an audit with the spirit of cooperation with the DOL. This is a serious matter which could potentially result in fines and penalties. You will want ERISA counsel in your corner, to review your proposed responses to the DOL and advise you as to strategy. ***Who is your "go to" counsel in case of a DOL Audit?***

Compliance is a series of actions, not a final destination. As a trusted advisor, Gallagher has developed this *Compliance Continuity* series to help you pursue a path through employee benefits compliance issues as part of an overall continuing compliance plan. Employers should carefully evaluate their health and welfare plans to determine if they are in compliance with both federal and state law. If you have any questions about one or more of the compliance destinations listed above, or would like additional information on how Gallagher constantly monitors laws and regulations impacting employee benefits in order to support employers in their compliance efforts, please contact your Gallagher representative.
